

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2011

APPROVED  
CMS NC 09380891

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		<div style="border: 2px solid black; padding: 5px; text-align: center;"> <b>RECEIVED</b>  MAY - 3 2011 C  04/19/2011 </div>	
NAME OF PROVIDER OR SUPPLIER  METCALFE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE AND ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42129			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.			
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and</p>	F 225	<p>1. An investigation into the skin tears experienced by resident #1 has been completed, with findings reviewed with the responsible party.</p> <p>2. An audit was completed by the DON/ADON of the last 2 weeks of skin assessments for all current residents to determine that all skin tears/bruises identified to be of unknown origin have been investigated and reported as indicated.</p> <p>3. The licensed nursing staff have received in-service education on the documentation, investigation and reporting of skin tears/bruises determined to be injuries of unknown origin as provided by the Nurse Consultant, DON, and ADON on 4/7, 4/21, 4/23, 4/26, 4/27, 5/2.</p> <p>4. Weekly skin assessments will be reviewed 2 times per month by the ADON to determine that all skin tears/bruises determined to be injuries of unknown origin have been investigated, and reported in accordance with facility policy and the regulatory requirements. The CQI indicator for the monitoring of the investigation and documentation of injuries of unknown origin will be utilized monthly times 2 months, and then every 6 months as per the established CQI calendar.</p>	5/8/11		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

*Angie Neighbors, adm* 5/2/11

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to investigate and report to appropriate state agencies injuries of unknown origin for one of three sampled residents (resident #1). Resident #1 received three skin tears from February 16, 2011 to April 13, 2011, however, the facility failed to investigate the skin tears and report as injuries of unknown origin.</p> <p>The findings include:</p> <p>Review of the facility policy "Resident Abuse," not dated, revealed the facility would investigate all events, such as suspicious bruising of residents, for occurrences, patterns, and trends that may have constituted abuse. All such events were to be monitored in accordance with the incident documentation policy and protocol for investigation of incidents of unknown origin. Further review revealed all alleged violations were to be reported to the appropriate state agencies.</p> <p>A review of resident #1's medical record revealed the resident was admitted to the facility on May 10, 2004. The resident's diagnoses included Anemia, Hypertension, Osteoarthritis, Chronic Obstructive Pulmonary Disease (COPD), and Dementia.</p> <p>A review of resident #1's quarterly Minimum Data Set (MDS) dated January 7, 2011, revealed</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>facility staff had assessed resident #1 to require total assistance of two staff persons for all activities of daily living. In addition, staff noted the resident had severe cognitive impairment.</p> <p>Observation of resident #1 on April 19, 2011, revealed staff was assisting the resident with bathing in the whirlpool tub. Skin tears, with steri-strips in place, were observed on the resident's left elbow, left forearm, and right forearm.</p> <p>A review of resident #1's Skin Assessments conducted by facility staff on February 16, 2011, revealed resident #1 had a skin tear with steri-strips in place on the right wrist. A review of the facility Event Report investigations revealed the facility had not conducted an investigation related to the right wrist skin tear. A review of a skin assessment performed by facility staff revealed resident #1 had a skin tear on the right elbow with steri-strips in place. However, a review of the facility's Event Report investigations revealed facility staff had failed to investigate the skin tear to resident #1's right elbow. Further review revealed on April 13, 2011, facility staff assessed resident #1 to have a skin tear on the left forearm with steri-strips in place. However, a review of the Event Report investigations for resident #1 revealed the facility had not performed an investigation related to the left forearm skin tear.</p> <p>Interview with certified nursing assistant (CNA) #1 on April 19, 2011, at 7:25 p.m., revealed if a CNA caused a skin tear or found a skin tear on a resident, the CNA was to notify a nurse. Further interview revealed CNA #1 had not taken care of resident #1 when a skin tear had occurred and</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>was not aware how resident #1 had received any of the skin tears.</p> <p>Interview with CNA #2 on April 19, 2011, at 7:03 p.m., revealed if a CNA caused a skin tear or observed a new skin tear, the CNA was to report the skin tear to a nurse. Further interview with CNA #2 revealed CNA #2 had never taken care of resident #1 when a skin tear had occurred, nor was the CNA aware of how resident #1 had obtained the skin tears.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on April 19, 2011, at 8:01 p.m., revealed when the LPN was made aware of a skin tear by facility staff the LPN was required to assess the skin tear, and interview facility staff as to how the skin tear, or any injury, had occurred. Further interview revealed the LPN would then document the injury, including how the injury occurred, if known, on an Event Report. At that time, according to the LPN, interventions would be put into place to prevent the event from happening again. LPN #1 further stated the event would be placed in the event report log, and the House Supervisor would be responsible to evaluate the event reports and to assure a follow-up was performed. Interview with LPN #1 further revealed if a resident received an injury, such as a skin tear, and facility staff was not aware of the origin of the injury, then the injury would be documented as an injury of unknown origin. LPN #1 stated he/she was unaware that injuries of unknown origin were required to be reported to the appropriate state agencies, and that he/she did not have the responsibility of reporting. Interview with LPN #1 further revealed the LPN had provided care for resident #1 (date unknown) when the resident had received a skin tear and</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>the LPN had filled out an event report related to the skin tear.</p> <p>Interview with LPN #2 on April 19, 2011, at 4:37 p.m., revealed if a skin tear was discovered or occurred during the provision of care to a resident, if facility staff caused a skin tear, or if the facility discovered an untreated skin tear the LPN was required to assess the skin tear and fill out an event report. LPN #2 further stated the event report was then placed into the event report log and the House Supervisor was responsible for reviewing all events and assuring reassessment was completed. Further interview revealed LPN #2 had provided care for resident #1 (date unknown) and the resident had sustained a skin tear. The LPN stated he/she did fill out an event report for the skin tear at that time.</p> <p>Interview with the House Supervisor (HS) on April 19, 2011, at 5:49 p.m., revealed the HS was required to review all event reports to assess for interventions that could have been put in place, to ensure the physician and responsible party were notified, and to ensure facility staff assessed the resident for 24 hours following the event. Interview further revealed if a resident had an injury and the facility was not aware how the injury had occurred then the injury would be noted as an injury of unknown origin. Further interview revealed the HS was not aware if an injury of unknown origin was required to be reported to appropriate state agencies, and stated the DON was responsible for reporting incidents to all appropriate state agencies.</p>	F 225			